Sep 21 2015 02:01pm P002/005 Printed: 09/08/2015

FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN ERVICES CENTERS FOR MEDICARE & MEDICAID

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 1

(X3) DATE SURVEY COMPLETED

495409

B. WING

09/08/2015

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

ABINGDON HEALTH CARE LLC

STREET ADDRESS, GITY, STATE, ZIP CODE

15051 HARMONY HILLS LANE ABINGDON, VA 24212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000	The section of the se	
K 038	Description of structure: One story Type V(111) exterior brick and vinyl veneer nursing home Sprinkler status: Fully sprinklered  An unannounced routine Life Safety Code survey was conducted September 8, 2015 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2000 NEW regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid.  The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483,70(a) et seq (life Safety from Fire.)		All findings as identified non-compliance with Title 42 Code of Regulations, 483.70 (a) et seq (life Safety from Fire) have been corrected	
SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1	K 038	K038 Corrected. The delayed egress exit door in the rear hallway by staff lounge was repaired/adjusted on day of survey to release within 15 seconds when the panic hardware is pressed continuously.	9/30/15
The control of the co	This Standard is not met as evidenced by: Based on observation and interview, the delayed egress exit door in the rear hall by the staff lounge did not release with 15 seconds when pushed.		All other exit doors with delayed egress have been checked and found to work in accordance to Title 42 Regulations and release with 15 seconds when the	A CANADA AND A CAN
Ì	The findings include: On September 8, 2015 at 1016 hours accompained by the Maintenance Director, the delayed egrees door in the rear hallway and next to the staff lounge did not release within 15 seconds when the panic harware was pushed. The Maintenance Director agreed with the findings.  Y DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN		panic hardware is pressed for 15 seconds.	

9-18.18

thy deficiency atalettient ending with an astetisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is retermined that that safaguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the fittilings stated above are disclosable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing tronies, the above findings and plans of correction are disclosable 14 lays following the date these documents are made evailable to the facility. If deficiencies are cited, all approved plan of confection is requisite to continued rogram participation.

Printed: 09/09/2015

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> IX21 MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED A. BUILDING 01 - BUILDING 1 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495409 09/08/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 15051 HARMONY HILLS LANE ABINGDON HEALTH CARE LLC ABINGDON, VA 24212 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (2051 (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 038 Continued from page one of one All exit doors with delayed egress will be checked by facility Maintenance two times weekly for four weeks followed K 038: NFPA 101 LIFE SAFETY CODE STANDARD K 038 by monthly inspections for 9 additional SS=D Exit access is arranged so that exits are readily. months. Records will be maintained for accessible at all times in accordance with section 7.1. audit inspections upon request. 18.2.1 Facility Maintenance will present such records for review to the Quality This Standard is not met as evidenced by: Assurance Committee and Facility Based on observation and interview, the delayed Safety Committee on a monthly basis egress exit door in the rear hall by the staff lounge did not release with 15 seconds when for three months and then quarterly for pushed. one year to ensure compliance to 42 The findings include: On September 8, 2015 at Code of Regulations and facility safety. 1016 hours accompained by the Maintenance The facility administrator ensure Director, the delayed egress door in the rear hallway and next to the staff lounge did not compliance to the regulations. release within 15 seconds when the panic harware was pushed. The Maintenance Director agreed with the findings. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (Xe) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing II is determined that other caregidates provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is regulable to continued program participation.

SJD121

Printed: 09/09/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (XI) PROMDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 - BUILDING 1 COMPLETED 495409 B. WING 09/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ABINGDON HEALTH CARE LLC 15051 HARMONY HILLS LANE ABINGDON, VA 24212 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) (O COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) PREFIX EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING THEORY MATIDIAL TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 051 NFPA 101 LIFE SAFETY CODE STANDARD K 051 K 051 Corrected. Fire Alarm system is SS=C A fire alarm system with approved components, maintained in accordance with NFPA 72 i devices or equipment is installed according to National Fire Alarm Code, and records NFPA 72, to provide effective warning of fire in of such maintenance are available for any part of the building. Activation of the complete fire alarm system is by manual fire review. Written records as specified in alarm initiation, automatic detection, or 7-5.2.2 NFPA have been obtained, are extinguishing system operation. Pull stations are located in the path of egress. Electronic or on site, and available as provided by the written records of tests are available. A reliable Contracted Vendor (Fire Life Safety second source of power is provided. Fire alarm systems are maintained in accordance with NFPA America, Inc.). 72, National Fire Alarm Code, and records of · maintenance are kept readily available. There is No other occurrences are identified to remote annunciation of the fire alarm system to K051 an approved central station. 18.3.4, 9.6 Education and requirements provided to contracted vendor (Fire Life Safety This Standard is not met as evidenced by: America) to provide all necessary Based on observation and interview, the records records in accordance to NFPA including for the annual testing of the fire alarm did not sections 7~5,2.2 upon routine comply with NFPA 72 (7-5.2.2), 1999 edition. inspections. The findings include: On September 8, 2015 at 1130 hours accompained by the Maintenance Facility Administrator will ensure that Director, A review of the fire alarm inspection vendor provides completed records as report records found that the records did not include all of the items specified in 7-5.2.2 NFPA required. Records will be presented to 72 1999 edition. The Maintenance Director facility safety committed for review and ! agreed with the findings.

safety inspections.

or directions as necessary and shall be filed with records for all routine fire

EPARIMENT OF HEALTH AND HUMAN SERVICES Abingdon HE ENTERS FOR MEDICARE & MEDICAID SERVY S		malth&Rehab Fax:	Sep 21 2015 02:02pm P005/005		
TATEMENT OF ISOLATED DEFICIENCIES WHILL CAUSE O HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM OR SNPs AND NPs		FROVIDER# 495469	DATE SURVEY COMPLETE: 09/08/2015		
AME OF PROVIDER OR SUPPLIER BINGDON HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA. 24212			
) REFIX	SUMMARY STATEMENT OF DEFICIENCIES				

K 130 NFPA 101 MISCELLANEOUS

٩G

OTHER LSC DEFICIENCY NOT ON 2786

This Standard is not met as evidenced by:

Based on observation and interview, there was an air conditioner obstructing the electrical panel in the electrical/data room.

The findings include: On September 8, 2015 at 1023 hours accompained by the Maintenance Director, there was an air conditioner obstructing the electrical panel in the electrical/data room. The Maintenance Director agreed with the findings. The air conditioner was moved out of the room during the insepction.

## K130 Corrected

The air conditioner was removed on day of survey. All other electrical/data rooms found clear of any items stored. Facility maintenance staff has been educated on not storing item(s) in electrical/data rooms. Facility safety committee members will monitor monthly for three months, followed by quarterly for 9 months to ensure no storage of such items and shall report findings to safety committee for review and/or direction by facility administrator. The facility administrator does assure compliance to K130. 9/30/15

ay deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined at other sufeguards provide sufficient protection to the patients. (See instructions.) Except for musting homes, the findings stated above are disclosable 1 days following the date of survey whether or not a plan of correction is provided. For musting homes, the above findings and plans of correction are solusable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is quisite to continued program participation.

ie above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	N SERVICES SERVICES	SFMO FILE NO. S-3751-001	2000 CODE	DE Form Approved OMB No. 0938-0242
FIRE SAFETY SURVEY REPORT 2000 CODE	ORT 2000 CODE - HEALTH CARE		MBER	1. (B) MEDICAID I.D. NO.
Medicar	Medicare - Medicaid	кі 495409	స	495409
	PART I – Life & Safe PART IV – Waiver	PART I – Life & Safety Code, New and Existing PART IV – Waiver Recommendation Form	:	the second secon
Identifying information as shown	shown in applicable records. Enter	changes, if any, along	Enter changes, if any, alongside each item, giving date of change	ate of change.
2. NAME OF FACILITY 2. (A.	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY	(STREET, CITY, STATE, ZIP CODE)	E) A. X Fully Sprinklered
Abingdon Health Care LLC	A. BUILDING 0101 B. WING C. FLOOR	15051 Hari Abingdon	15051 Harmony Hills Lane Abingdon, Virginia 24211	(Not all required areas are sprinklered)  [Not all required areas are sprinklered]
K3				C. ☐ None (No sprinkler system) K0180
3. SURVEY FOR X MEDICAID 4. DA	September 8, 2015	DATE OF PLAN APPROVAL  February 3, 201	SURVEY UNDER  5. [] 2000 EXISTING  K7	6. <b>X</b> 2000 NEW
SURVEY FOR CERTIFICATION OF     SKILLED/NU     Z. ★ SKILLED/NU	X SKILLED/NURSING FACILITY 4. □ ICF/MR	□ ICF/MR UNDER HEALTH CARE	5. 🗆 HOSPICE	
IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW  1. X ENTIRE FACILITY 2.   D DISTINCT PART OF (SPECIFY)	ROPRIATE ITEM(S) BELOW T OF (SPECIFY)	3.	☐ IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED BY JCAHO/AOA?	IS HOSPITAL ACCREDITED BY
3	THE REPORT OF THE PROPERTY OF		a. □ YES	b. 🗆 NO
물걸照	SPITAL BEDS c. NUMBER OF SKILLED BEDS GERTIFIED FOR MEDICARE	120	d. NUMBER OF SKILLED BEDS e. NUM CERTIFIED FOR MEDICAID 129 CER	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID 0
7. A. X THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES) 1. COMPLIANCE WITH ALL PROVISIONS 2. X ACCEPTANCE OF A PLAN OF B. C. THE FACILITY DOES NOT MEET THE STANDARD	(CHECK ALL APPROPRIATE BOXES)  3. 2. X ACCEPTANCE OF A PLAN OF CORRECTION STANDARD	RRECTION 3. 🗆 RECOMMENDED WAIVERS		4. □ FSES 5. □ PERFORMANCE BASED DESIGN
SURVEYOR (Signature) SURVEYOR ID  12589	TITLE Asst. Fire Marshal	OFFICE Virginia State I Southwester	State Fire Marshal's Office western Regional Office Chilhowie, Virginia	9/9/2015
Clark & Brown & Printer & Continue & Continu	TITLE Fire Marshal Manager	OFFICE Virginia State I Southweste	Fire Marshal's Office rn Regional Office e, Virginia	9/21/2015
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays this information collection is 0938-2042. The time required to complete this information collection is estimated to average 5 minutes ped data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the form places with a CMC Att. Days of the CMC Att. Days of the concerning the form places with a CMC Att. Days of the concerning the form places with a CMC Att. Days of the concerning the	According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-2042. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 75000 Security Boulevier Boulevier 15000.	ion of information unless it displays sestimated to average 5 minutes per layer any comments concerning the Manuland 21744 1850	a valid OMB control number. The valid OMB control number for response, including the time to review instructions, search existing e accuracy of the time estimate(s) or suggestions for improving this	d OMB control number for w instructions, search existing uggestions for improving this

Form CMS-2786R (06/07)

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## FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

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